

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-028976

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 160

Primary Registration District No. 559

Registrar's No. 102

DO NOT WRITE
ON THIS STUD

AMENDED

FILED JUL 24 1963

VS 300
Rev. 4/59

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USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Champaign	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Joachim Twp.		c. CITY OR TOWN Urbana	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mountain View Nursing Home		d. STREET ADDRESS (If outside, give location) 1103 W. Springfield	
3. NAME OF DECEASED (Type or print) First Middle Last Harriet Louisa Richards		4. DATE OF DEATH Month Day Year July 15, 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/2/1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Ohio	
13a. FATHER'S NAME Gilbert Beard		14. NAME OF HUSBAND OR WIFE Thomas E. Richards	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Address F. E. Richards, 11395 Inverness Lane St. Louis, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 7-9-57 to 7-15-63 and last saw her alive on 7-14-63 Death occurred at 7:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. P. D. Smith, M.D.		22b. ADDRESS 112 MISSISSIPPI AVE CRYSTAL CITY, MISSOURI	
22c. DATE SIGNED 7-15-63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/17/63	23c. NAME OF CEMETERY OR CREMATORY Sterns Cemetery	
24. FUNERAL DIRECTOR Freese Funeral Home, St. Joseph, Ill		25. DATE RECD. BY LOCAL REG. 7/16/63	
26. REGISTRAR'S SIGNATURE John R. Bell, Deputy			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Not Embalmed, Student Embalmer No. _____,
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald H. Weingard

Licensed Embalmer No. 4608

P. O. Address Fresno, Cal.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.